Docket No.: 462322000100
(PATENT)

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

IN RE APPLICATION OF:	WILLIAM D. KIRSCH *ET AL.*	EXAMINER:	R.W. MORGAN
APPLICATION NO.:	09/784,045	ART UNIT:	3626
FILED:	FEBRUARY 16, 2001	CONF. NO:	2531

FOR: **SYSTEM AND METHOD FOR STANDARDIZED AND AUTOMATED APPEALS PROCESS**

MS Appeal Brief - Patents
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

RESPONSE TO NOTIFICATION OF NON-COMPLIANT APPEAL BRIEF

In response to the Notification of Non-Compliant Appeal Brief mailed March 25, 2010, Appellants submit a revised Status of Claims and Summary of Claimed Subject Matter, amending portions of the Opening Brief filed March 23, 2010, which the Office determined were not in compliance with the applicable provisions of 37 CFR §41.37.

Appellants are appealing the rejection of claims 1-11, 14-21 and 23 dated August 31, 2009. A Notice of Appeal was filed on December 23, 2009. Appellants request that the rejection of claims 1-11, 14-21 and 23 be reversed.

(1) Real Party In Interest

The real party in interest is e-Appeals, LLC, of Hollywood, Florida, the assignee of the above-captioned application.

(2) Related Appeals and Interferences

There are no appeals or interferences known to Appellants.

(3) Status of Claims

Claims 1-21 and 23 are pending, currently stand rejected, and have been rejected at least twice. Claims 1-11, 14-21 and 23 are being appealed. Claims 12 and 13 are not on appeal. Claim 22 has been cancelled by amendment and is no longer pending. A copy of the appealed claims as they presently stand is included in the Claims Appendix.

(4) Status of Amendments

No amendments have been filed subsequent to the Office Action mailed on August 31, 2009.

(5) Summary of Claimed Subject Matter

The following description relates to independent claims 1-4, 7, 8, 11, 14, 15, 21 and 23 to the extent that common subject matter is recited. All of Appellants' pending independent claims on appeal relate to the automated processing of insurance appeals, and in particular, appeals relating to healthcare insurance claims. Healthcare insurance and appeals relating to that insurance are typically governed by contract and are regulated by state and federal law. An insurance appeal may arise when an insurance company has made a determination that is unfavorable to an insured concerning whether the insured is entitled to a benefit or service in accordance with an insurance contract or under a law. An appeal may be filed either by a consumer, such as a patient, or by a provider, such as a physician. As examples, a consumer may file an appeal when a request for approval to receive medical treatment is denied or a claim is not paid. A healthcare provider may file an appeal when an insurer has not paid for a service rendered. (Page 1, lines 12-18.) Often, claims are denied because either information is missing from the claim form or the provider contract is loaded incorrectly into an insurance company database. (Page 2, lines 20-22.) The specification describes systems and methods for a standardized and automated appeals process over a network for appealing denials of these insurance claims and other types of benefits. (Page 1, lines 3-5.)

Independent claims 1-4, 7, 8, 11, 14, 15, 21, and 23 recite combinations of receiving appeals data, processing the data, and forwarding the processed data to a payer such as an appeals agency. In connection with independent claims 1-4, 7, 8, 11, 14, 15, 21, and 23, the specification describes that information relating to the user and the user's appeal is received from a user or remote station. (Page 15, line 6-page 19, line 6 and page 24, line 4-line 14.) The received data is stored and further processed so that it can be later presented to a payer in a standardized format. (Page 24, lines 15-20.) This processed data is then sent to an appeals agency, appeals unit, or other form of payer for reconsideration. (Page 19, line 15-page 20, line 15 and page 21, line 16-page 22, line 5.) During the appeal process, the user can be notified of the status of the appeal. (Page 26, lines 1-2.)

Independent claim 14 further recites electronically assigning a substantially unique appeal number to the collected data, the appeal number associating the appeal data with the user profile in a computerized system. (Page 15, lines 16-19, page 16, lines 10-12, page 18, lines 9-11.)

Independent claim 23 further recites automatic identification of a regulatory agency for an appeal. (Page 11, lines 4-7, page 21, lines 7-10, and page 26, lines 7-14.)

(6) Grounds of Rejection to be Reviewed on Appeal

(a) The rejection of claim 23 as containing new matter is appealed.

(b) The rejection of claims 1, 3, 4, and 6-8 as obvious in light of Burchetta is appealed.

(c) The rejection of claims 2 and 11 as obvious in light of Burchetta in combination with Israel is appealed.

(d) The rejection of claim 5 as obvious in light of Burchetta in combination with Barber is appealed.

(e) The rejection of claims 9 and 10 as obvious in light of Burchetta in combination with Official Notice is appealed.

(f) The rejection of claim 14 as obvious in light of Burchetta in combination with Newswire is appealed.

(g) The rejection of claims 15-21 as obvious in light of Burchetta in combination with Newswire is appealed.

(h) The rejection of claim 23 as obvious in light of Burchetta in combination with Newswire and Official Notice is appealed.

(7) Argument

A. Claim 23 does not introduce new matter as alleged in Grounds of Rejection (6)(a).

Claim 23 was rejected under 35 U.S.C. §112, first paragraph, as containing subject matter allegedly not supported by the original disclosure. A teleconference with the Examiner was held on March 22, 2010, in which this rejection was confirmed to be withdrawn. Specifically, it was noted that, in the Examiner's Answer mailed on December 9, 2008, the Examiner withdrew this rejection, stating that "[i]n response to the first argument, the Examiner respectfully submits that objected to under 35 U.S.C. § 112, first paragraph to claim 23 has been withdrawn." (Answer of Dec. 9, 2008, at 33.) This rejection was also withdrawn in the Examiner's Answer mailed on September 13, 2007 (Answer of Sept. 13, 2007, at 32) and the withdrawal was acknowledged by Appellants in the Reply Brief mailed on November 13, 2007. (Reply Brief of Nov. 13, 2007, at 2.)

In the teleconference of March 22, 2010, the Examiner agreed that the rejection of claim 23 under 35 U.S.C. § 112, first paragraph, and the corresponding objection under 35 U.S.C. § 132 were made through inadvertence and would not be maintained in further prosecution. Appellants thank the Examiner for this clarification and do not address those issues further here, as they have been effectively mooted.

B. Burchetta does not teach an appeal that relates to a request for reconsideration of a claim adjudicated by an insurer and there is no evidence in the record to support the assumptions relied upon by the Examiner in rejecting claims 1-11 and 14 in Grounds of Rejections (6)(b)-(e).

Claims 1-11 and 14 stand rejected under 35 U.S.C. §103(a) as being unpatentable over U.S. Patent No. 6,330,551 entitled "Computerized Dispute Resolution System and Method" by Burchetta et al. ("Burchetta"), alone or in combination with other references.

Independent claims 1, 2, 3 and 7 of present application recite that "the appeal is a request for reconsideration of a claim adjudicated by an insurer." Independent claims 4, 8, 11 and 14 recite that "the appeal...information relates to a request for reconsideration of a claim adjudicated by an insurer." Burchetta, however, does not describe "a request for reconsideration of a claim adjudicated by an insurer." Rather, Burchetta is directed to "a computerized system for automated dispute resolution...for communicating and processing a series of demands to satisfy a claim made by or on behalf of a person involved in a dispute with at least one other person and a series of offers to settle the claim." (Burchetta at col. 3, lines 47-52, emphasis added.) Thus, Burchetta only describes an iterative negotiation process whereby two parties can negotiate a specific dollar amount for settlement of a claim.

The Examiner has admitted that Burchetta fails to teach an appeal that is a request for reconsideration of a claim adjudicated by an insurer. (See August 31, 2009, Office Action at 5.) The Examiner recognized this shortcoming of Burchetta and stated that "[t]he Examiner considers a dispute that is not pending as a claim that has been adjudicated by one of the parties involved such as the insurer." (Office Action at 5.) Appellants respectfully submit that Burchetta does not teach or suggest an "appeal" that is "a request for reconsideration of a claim adjudicated by an insurer." Rather, Burchetta only describes a "demand" which is defined by Burchetta to be "the amount of money required by the person having a claim...against another person...such as a defendant or his

insurer, for which the person with the claim would be willing to settle." (Burchetta at col. 3, lines 54-57.)

In the Office Action at 5, the Examiner stated, and Appellants do not disagree, that Burchetta teaches a computerized system for automated dispute resolution of claims that may or may not be in litigation. In contrast to the claimed invention, however, Burchetta presupposes that a cognizable claim for money against an insurer or another party already exists. The systems and methods recited in the claims are not directed to an individual having a claim for any amount of money. Rather, the pending claims relate to sending information to an appeal unit for reconsideration of a claim adjudicated by an insurer. The claims do not recite a demand for money or the transfer of any amount of money from one party to another, *per se.*

Because Burchetta fails to teach the claimed "request for reconsideration of a claim adjudicated by an insurer," the Examiner attempted to provide that teaching without relying on Burchetta by simply stating what the Examiner considers the automated dispute process of Burchetta to be. Appellants respectfully submit that the Examiner has impermissibly considered the automated dispute of Burchetta to be as he has described it and has failed to identify any basis in Burchetta for the Examiner's conclusion.

In the Office Action at 5, the Examiner stated that "[t]he Examiner considers a dispute that is not pending as a claim that has been adjudicated by the one of the parties involved such as the insurer." Appellants submit that it is an insufficient basis for a rejection of the claims that "the Examiner considers" the demand for money disclosed by Burchetta to be the claimed request for reconsideration of a claim that has been adjudicated by an insurer. It is insufficient because the Examiner has failed to provide any evidence at all for his "consider[ation]." In the Examiner's Answer mailed December 9, 2008, at 34, the Examiner supported this rejection with a citation to *In re Graves,* 36 USPQ 2d 1697 (Fed. Cir. 1995). Appellants respectfully submit that *In re Graves* does not support the Examiner's rejection here because *In re Graves* requires that the Examiner rely

on evidence in the record that one of ordinary skill in the art would make the same consideration. In an analogous situation, the Board in *Ex parte Donaldson* (Unpublished BPAI opinion in Appeal No. 1998-0595), concluded that *In re Graves* was inapplicable:

> As for the Federal Circuit's decision in *In re Graves...*, which the examiner also cited, it appears that the examiner is relying on the notion that what is otherwise known to one with ordinary skill in the art need not be described in a prior art reference. That, however, does not help the examiner's position here, because the examiner has made no demonstration based on evidence in the record that putting a spindle synchronization command...was known to one of ordinary skill in the art.

(Ex parte Donaldson, emphasis added.) The only basis for the Examiner's rejection of the pending claims as obvious is a review of Appellant's disclosure and the application of an unsupported consideration. The Examiner's unsupported consideration that the automated dollar disputes of Burchetta are claims that have been adjudicated by an insurer cannot form a basis for a rejection of the claims. The Examiner's basis for the rejection in this case is no better supported than the basis found to be insufficient in *Ex parte Donaldson* which, while not precedential, is indicative of how the Board addresses this type of issue.

Appellants respectfully submit that the MPEP also suggests that this rejection should be reversed. MPEP §2144.03 relies on *In re Zurko* and states that "[i]t is never appropriate to rely solely on 'common knowledge' in the art without evidentiary support in the record, as the principal evidence upon which a rejection was based. *In re Zurko,* 258 F.3d 1379, 1385,59 USPQ2d 1693, 1697 (Fed. Cir. 2001) ('[T]he Board cannot simply reach conclusions based on its own understanding or experience-or on its assessment of what would be basic knowledge or common sense. Rather, the Board must point to some concrete evidence in the record in support of these findings.')".

As the court held in *Zurko,* an assessment of basic knowledge and common sense that is not based on any evidence in the record lacks substantial evidence support. *Id.* at 1385, 59 USPQ2d at

1697. See also *In re Lee,* 277 F.3d 1338, 1344-45,61 USPQ2d 1430, 1434-35 (Fed. Cir. 2002) (In reversing the Board's decision, the court stated "'common knowledge and common sense' on which the Board relied in rejecting Lee's application are not the specialized knowledge and expertise contemplated by the Administrative Procedure Act. Conclusory statements such as those here provided do not fulfill the agency's obligation....The board cannot rely on conclusory statements when dealing with particular combinations of prior art and specific claims, but must set forth the rationale on which it relies.").

Because Burchetta fails to teach "a request for reconsideration of a claim adjudicated by an insurer" and the Examiner cannot rely on unsupported considerations to fill that gap, Appellants respectfully request that the rejection of claims 1-11 and 14 be reversed.

C. Burchetta does not teach electronically assigning a substantially unique appeal number to the collected data, the appeal number associating the appeal data with the user profile in a computerized system and there is no evidence in the record to support the assumptions relied upon by the Examiner in rejecting claim 14 in Grounds of Rejection (6)(f).

Claim 14 stands rejected under 35 U.S.C. §103(a) as being unpatentable over Burchetta in combination with Newswire.

Independent claim 14 of present application recites "electronically assigning a substantially unique appeal number to the collected data, the appeal number associating the appeal data with the user profile in a computerized system." In the Office Action at 24, the Examiner recognized that Burchetta fails to teach this feature. The Examiner then relied on Newswire to complete the obviousness rejection, stating that "[t]he Examiner interprets sorting by date and the provider ID" to teach the claimed feature of "assigning a substantially unique appeal number to the collected data." (Office Action at 24.)

Appellants submit that it is an insufficient basis for a rejection of the claims that "the Examiner interprets" a basic sorting function to be the claimed "assigning a substantially unique

appeal number to the collected data." It is insufficient because the Examiner has failed to provide any evidence at all for his conclusion. There is no suggestion of any sort in Newswire that the capability to sort data is, in any way at all, related to a "substantially unique appeal number." The Examiner has identified no teaching in Newswire at all that supports the Examiner's conclusion. Rather, the Examiner has merely provided an unsupported statement that Newswire is "interpret[ed]" to teach the claimed feature. In light of the complete lack of any supporting evidence or rationale in the prosecution record, Appellants respectfully request that the rejection of claim 14 be reversed.

D. Burchetta does not teach an appeal that relates to a request for reconsideration of a determination of entitlement to benefits or services and there is no evidence in the record to support the assumptions relied upon by the Examiner in rejecting claims 15-21 and 23 in Grounds of Rejections (6)(g) and (6)(h).

Claims 15-21 and 23 were also rejected under 35 U.S.C. §103(a) as being unpatentable over Burchetta. Independent claims 15 and 21 recite that "the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services." Independent claim 23 recites that "the appeal relates to a request for reconsideration of a determination of entitlement to a benefit, service or payment."

In the Office Action, the Examiner stated that this feature is taught by the description in Burchetta of a central processing unit that receives information corresponding to three settlement offers and that a plaintiff or claimant can enter three demands over a period of time. (See Office Action at 25 and Burchetta at col. 2, lines 3-6.) While Appellants acknowledge that Burchetta teaches receipt of a series of demands and offers, Appellants respectfully submit that Burchetta does not teach or suggest any form of "appeal" that "relates to a request for reconsideration of a determination of entitlement to benefits or services."

As discussed above, Burchetta is not analogous and is completely unrelated to the claimed invention. Burchetta describes only that a "demand" is "the amount of money required by the person having a claim...against another person...such as a defendant or his insurer, for which the person with the claim would be willing to settle." (Col. 3, lines 54-57.) Burchetta describes that an "offer" is "the amount of money the defendant or the insurance company will settle the claim." (Col. 3, lines 61-63.) Thus, the offer and demand of Burchetta are nothing more than dollar amounts. Burchetta describes a process whereby two parties can agree, through a negotiation process, on a dollar amount to be paid on a claim. Burchetta does not describe anything that relates to a "determination of entitlement."

In the Office Action, the Examiner has not provided any support for the conclusion that Burchetta teaches the claimed feature. (See Office Action at pages 25-26.) Appellants respectfully submit that, as discussed above, the Federal Circuit and the Board have found that this type of unsupported consideration cannot form a basis for a rejection of the claims and respectfully request that the rejection of claims 15-21 and 23 be reversed.

E. Newswire does not teach selecting a reason for an appeal of a denial as alleged in Grounds of Rejection (6)(g) and (6)(h).

Claims 15-21 and 23 stand rejected under 35 U.S.C. §103(a) as unpatentable over Burchetta in view of a press release entitled "Cardiff Software Announces TELEform MediClaim Module" ("Newswire").

Newswire teaches software for automated medical claims processing. Newswire describes that the software begins by optically scanning handwritten or machine print medical claim forms. After recognition, the data is then validated. Newswire teaches, at paragraph 13, that the validation step includes checking for mismarked or illegible entries, correcting errors, and checking all fields for formatting and content. After validation, the software can export data in certain standard

formats. Thus, the validation of Newswire is nothing more than a check to confirm that the data read in does not have obvious faults.

In rejecting claims 15-21 and 23, the Examiner recognized that Burchetta fails to teach associating appeal data with one or more bases for an appeal and turned to Newswire to complete the obviousness rejection. (See Office Action at 26.) Appellants submit that Newswire also fails to teach the features of "automatically selecting a reason for an appeal of the denial, the selection being based upon the appeal data" of claim 15 or "processing the stored appeal data to identify a basis for an appeal" of claim 21.

Appellants do not disagree with the Examiner that Newswire teaches a MediClaim module that performs optical character recognition (OCR) and validation on medical claim information. (Office Action at 26.) However, Appellants respectfully submit that Examiner has misinterpreted the validation step to include generating a reason for an appeal. Appellants submit that Newswire is unrelated to the claimed invention and does not teach "selecting a reason for an appeal."

Appellants submit that Newswire fails to teach selecting a reason for an appeal based upon appeal data, automatically or otherwise. Newswire does not teach a system capable of selecting a reason of any kind for any purpose. Newswire teaches a very simple system that performs OCR on medical claim data and then checks that data to ensure that it complies with certain conventions. There is no suggestion that an appeal has taken place or will take place. There is also no suggestion of a basis for such an appeal.

In the Office Action at 26-27, the Examiner stated that the customized validations on ICD-9 and CPT data teach "data descriptive of a plurality of insurance appeals." Appellants submit that one of ordinary skill in the art would recognize that ICD-9 and CPT data are diagnostic and treatment coding schemes. These schemes provide standardized codes for medical procedures and have the general purpose of facilitating billing and data collection for medical procedures and conditions. Even if the codes referenced in Newswire could somehow be used in connection with

an insurance appeal, there is no suggestion anywhere in Newswire that these standardized codes can be the basis for selecting a reason for an insurance appeal.

Appellants therefore respectfully request that the rejection of claims 15-21 and 23 be reversed.

F. The prior art fails to teach automatically identifying a regulatory agency as alleged in Grounds of Rejection (6)(h).

The Examiner rejected claim 23 as unpatentable over Burchetta in combination with Newswire and further in view of Official Notice.

The rejection of claim 23 appears to rely upon Newswire to teach the claimed feature of "an appeal submission...according to a predetermined format." As discussed above, Newswire never mentions an appeal and therefore does not teach an appeal submission...according to a predetermined format.

In rejecting claim 23, the Examiner recognized that neither Burchetta nor Newswire teach the claimed feature of

"receiving appeal data at a computerized appeals processor, the data comprising:

data descriptive of a denial of a benefit, service or payment;

an identification of a state in which a health care service was provided; and

an identification of a type of health care insurance;

automatically identifying a regulatory agency appropriate for an appeal using the computerized appeals processor, the identification being based upon the identified state and the type of health care insurance in the received appeal data." (See Office Action at 29.)

To complete the obviousness rejection, the Examiner took Official Notice "that in the medical industry state laws and regulations provide guidance to physician and patient in determine [sic] reimbursement amounts or appeal information for health insurance claims." The Examiner then concluded that "it would have been obvious to...include identifying the state and type of health

care insurance regarding the appeal information with the system [of Burchetta and Newswire]." (Office Action at 30.)

Appellants submit that the Examiner has not made a prima facie case of obviousness. The Examiner has not alleged that any prior art reference teaches "automatically identifying a regulatory agency... the identification being based upon the identified state and the type of health care insurance."

Furthermore, Appellants do not concede that it is a common fact appropriate for Official Notice that "laws and regulations...determine reimbursements amounts of appeal information." Reimbursement amounts in this context are more properly a matter of contract between the insured and insurer. Appellants are unaware of any law or regulation that mandates reimbursement amounts on an appeal and the Examiner has not identified any such law or regulation. Appellants further submit that the Official Notice, even if based on well-known facts or common knowledge, is insufficient to support the rejection. The purported fact that medical industry regulations inform parties of reimbursement amounts for insurance claims is irrelevant to and fails to teach "automatically identifying a regulatory agency appropriate for an appeal."

It is axiomatic that in forming an obviousness rejection, each claimed feature must be identified in the prior art. In rejecting claim 23, the Examiner recognized that the prior art fails to teach certain claimed features, took Official Notice of a purported fact that also does not teach the missing feature, and then rejected the claim as obvious in light of that purported fact. Appellants submit that the Examiner has not identified any teaching of "automatically identifying a regulatory agency appropriate for an appeal" in the prior art. Appellants therefore respectfully request that the rejection of claim 23 be reversed.

G. Conclusion

Appellants submit that the pending dependent claims are also patentable for the reasons given above and respectfully request reversal of the rejections.

In the event the U.S. Patent and Trademark Office determines that an extension and/or other relief is required, Appellants petition for any required relief including extensions of time and authorizes the Commissioner to charge the cost of such petitions and/or other fees due in connection with the filing of this document to Deposit Account No. 03-1952 referencing docket no. 462322000100.

Dated: April 23, 2010

Respectfully submitted,

By _____
James M. Denaro
Registration No.: 54,063
MORRISON & FOERSTER LLP
1650 Tysons Blvd, Suite 400
McLean, Virginia 22102
(703) 760-7731

Claims Appendix

1. A computerized method for an automated appeal process for a provider, comprising:

receiving provider identification from a remote provider computer by an electronic network;

receiving appeal data from the remote computer by the network, wherein the appeal data comprises data descriptive of a plurality of insurance appeals;

electronically storing the appeal data from the remote computer in a computerized appeals database;

sending the appeal data to an appeals unit by the network;

receiving appeal status information for a plurality of appeals from the appeals unit by the network; and

sending appeal status information to a provider at the remote computer by the network, wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

2. A computerized method for an automated appeal process for a user, comprising:

collecting user information and appeal data from a user;

electronically storing the collected data in a computerized database;

electronically transmitting the appeal data to an appeals agency;

receiving a status of an appeal from the appeals agency;

storing the status of the appeal in the computerized database; and

sending the status of the appeal to the user, wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

3. A computerized system for an automated appeal process for a user, comprising:

a server computer connected to a remote computer for receiving appeal data from the remote computer; and

an electronic database for storing the appeal data, wherein the server computer is further configured or arranged to:

transmit an appeal form to the user at the remote computer;

receive an appeal form containing appeal data from the user;

process the appeal form to generate an appeal having a predetermined format;

send the formatted appeal to an appeals unit; and

send a status report to the user at the remote computer, wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

4. A computerized method of automating an appeals process, comprising:

electronically collecting user information from a user and storing the user information;

presenting the user with a claim denial form;

electronically collecting claim denial information and storing the claim denial information in a computerized database;

presenting the user with a patient information form;

electronically collecting patient information and storing the patient information in the computerized database;

presenting the user with a provider information form;

electronically collecting provider information and storing the provider information in the computerized database;

electronically collecting appeal status information on an adjudicated claim and storing the appeal status information in the computerized database;

presenting the user with a check appeal status form; and

electronically collecting check appeal status information and presenting the user with appeal status information based on the check appeal status information collected, wherein the appeal status information relates to a request for reconsideration of a claim adjudicated by an insurer.

5. The method according to claim 4, further comprising:

presenting the user with a credit card information form; and

collecting credit card information and storing the credit card information.

6. The method according to claim 4, further comprising presenting an administrative interface including information on an appeal submitted.

7. A computerized method for an automated appeal process, comprising:

electronically receiving a login request from a user;

electronically displaying a welcome screen to the user;

electronically receiving a first user selection from the user;

electronically displaying a first user screen based on the first user selection;

electronically receiving user identification information from the user;

electronically displaying a second user screen based on the user identification information;

electronically receiving a second user selection from the user; and

electronically displaying a third user screen based on the second user selection, the third user screen for a new appeal,

wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

8. A computerized method for automating an appeal process, comprising:

receiving appeal data descriptive of a plurality of appeals from a remote computer;

electronically storing the collected data in a computerized database;

electronically converting appeal data from one or more of the plurality of appeals to a predetermined appeal format; and

electronically transmitting at least a portion of the converted appeal information to an appeals unit, wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

9. The method of claim 8, wherein the conversion further comprises converting the information to conform with a format described by a public law.

10. The method of claim 8, wherein the conversion further comprises converting the information to conform with a format described by a public regulation.

11. A computerized method for automating an appeal process, comprising:

receiving appeal data descriptive of a plurality of appeals from a remote computer;

electronically storing the received appeal data in a computerized database;

electronically converting appeal data from one or more of the plurality of appeals to a predetermined appeal format;

programmatically applying one or more rules to select one or more of the plurality of appeals; and

sending data descriptive of one or more selected appeals to an appeals agency, wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

14. A computerized method for an automated appeal process, comprising:

collecting user profile information and appeal data from a data provider;

electronically storing the collected data in a computerized appeals database;

electronically assigning a substantially unique appeal number to the collected data, the appeal number associating the appeal data with the user profile in a computerized system;

electronically transmitting the appeal data to an appeals unit by an electronic network;

receiving a status of an appeal from the appeals unit;

electronically storing the status of the appeal in the appeals database; and

electronically transmitting the status of the appeal to the data provider, wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

15. A computerized method for an automated appeal process, comprising:

receiving appeal data descriptive of a denial of a benefit, service or payment;

automatically selecting a reason for an appeal of the denial, the selection being based upon the appeal data;

electronically generating an appeal submission including the selected reason for an appeal and arranged and according to a predetermined format using a computerized system; and

electronically sending the formatted appeal submission to an appeals agency, wherein the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services.

16. The method of claim 15, wherein the selection of a reason for an appeal is based on results of a previously submitted claim or appeal.

17. The method of claim 15, wherein the appeal data comprises data descriptive of a plurality of insurance appeals.

18. The method of claim 15, further comprising extracting available data elements from a standardized data form.

19. The method of claim 18, wherein the standardized data form is an HCFA 1500, NSF version 2.0 or 3.0 UB92, or ANSII data form.

20. The method of claim 18, wherein the standardized data form is a HIPAA 835 or HIPAA 837 data form.

21. A computerized method for an automated appeal process, comprising:

receiving appeal data from a remote computer;

electronically storing the appeal data from the remote computer in a computerized database;

computer processing the stored appeal data to identify a basis for an appeal;

automatically generating an appeal submission comprising the identified basis for the appeal and according to a predetermined format; and

sending the formatted appeal submission to an appeals unit, wherein the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services.

23. A computerized method for an automated appeal process, comprising:

receiving appeal data at a computerized appeals processor, the data comprising:

data descriptive of a denial of a benefit, service or payment;

an identification of a state in which a health care service was provided; and

an identification of a type of health care insurance;

automatically identifying a regulatory agency appropriate for an appeal using the computerized appeals processor, the identification being based upon the identified state and the type of health care insurance in the received appeal data;

electronically generating an appeal submission comprising the data descriptive of the denial of the benefit, service or payment and arranged according to a predetermined format; and

electronically sending the formatted appeal submission to the identified regulatory agency by an electronic network, wherein the appeal relates to a request for reconsideration of a determination of entitlement to a benefit, service or payment.

Evidence Appendix

[No evidence presented]

Related Proceedings Appendix

[No related proceedings presented]